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In The Supreme Court of the United States

JOHN D. ASHCROFT, ATTORNEY GENERAL, ET AL.,

Petitioners,

v.

ANGEL McCLARY RAICH, ET AL.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF OF THE DRUG FREE AMERICA FOUNDATION, INC., THE DRUG FREE SCHOOLS COALITION, SAVE OUR SOCIETY FROM DRUGS, THE INTERNATIONAL SCIENTIFIC AND MEDICAL FORUM ON DRUG ABUSE, THE INSTITUTE ON GLOBAL DRUG POLICY, AND STUDENTS TAKING ACTION NOT DRUGS, ET AL., AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

Whether the Controlled Substances Act, 21 U.S.C. 801 *et seq.*, exceeds Congress's power under the Commerce Clause as applied to the intrastate cultivation and possession of marijuana for the purported personal "medicinal" use or to the distribution of marijuana without charge for such use?

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INTEREST OF *AMICI*

Amici Curiae are parents, drug-prevention organizations, distinguished medical and scientific experts, policy makers, non-profit corporations, business owners and others who are concerned with preventing drug abuse, and who all share a common concern that smoked or crude marijuana is disingenuously referred to as medicine. The international makeup of Amici reflects the international concern that illicit drug use is undercutting traditional values and threatening the very existence of stable families, communities, and government institutions throughout the world. Amici collectively support families, communities, and nations that are free of illicit drug use, drug abuse, drug addiction, and drug-related deaths through advocacy and solid medical and scientific research and oppose the de jure and de facto legalization of marijuana and all other current illicit drugs. Smoked or "crude" marijuana is a dangerous Schedule I drug, notwithstanding creative attempts by those who seek its legalization to label its use as "compassionate" in medical settings. Medical marijuana initiatives now enacted in ten states and the District of Columbia undermine national drug-enforcement priorities and our well-designed federal system of approval of new drugs. While future use of the state ballot initiative process as a tool to replace the legislative process must be dealt with by state legislatures, ultimately the federal government and courts must address this important issue to ensure a consistently applied and clearly understood national drug policy, as well as to preserve the Food and Drug Administration's medical and scientific new drug approval process that protects Americans from unsafe, ineffective drugs. This brief is submitted to present to the Court current research which confirms

that the drug marijuana continues to have no currently accepted medical use.

The complete list of *amici* is listed in the Appendix, as App. 8.

SUMMARY OF ARGUMENT

There is still no proven medical value to the use of crude marijuana. This remains the unequivocal position of the Food and Drug Administration, which is charged by Congress with making this determination. The Appellate Court's decision (finding a strong likelihood of success on the merits of appellants' commerce clause claim) rests on its identification of a *separate class* of activities regarding the use of crude marijuana for personal medical purposes, such that this class of activities exists outside the scope of the class of drug-related activities reached by the Controlled Substances Act, 21 U.S.C. § 801 *et seq.* Absent a legitimate and currently accepted medical use for crude marijuana, the Appellate Court's reasoning must fail, as it would therefore have no basis for establishing this separate class of drug use which is independent of the Controlled Substances Act. As demonstrated herein, both federal law and the weight of medical research continue to find crude marijuana use to be dangerous and without legitimate medical application. Therefore the Appellate Court's necessary foundational premise (i.e., the existence of private, non-commercial *medical* use of marijuana) is invalid, and the "separate class of activities" envisioned by the Appellate Court cannot exist. Simply put, if there is no currently accepted medical use for marijuana, then the activity at issue must, by the appellate court's own analysis,

fall within the jurisdictional scope of the Controlled Substances Act, pursuant to its authority under the Commerce Clause, and therefore there is no possibility of success on the merits of the appellant's commerce clause claim, and the decision below must be reversed.

ARGUMENT

I. BECAUSE CRUDE MARIJUANA[1] HAS NO CURRENTLY ACCEPTED MEDICAL USE, ITS PURPORTED MEDICAL USE CANNOT CONSTITUTE A CLASS OF ACTIVITIES SEPARATE FROM THE ACTIVITIES REGULATED BY THE CONTROLLED SUBSTANCES ACT ("CSA"), AND THE CSA, PURSUANT TO THE COMMERCE CLAUSE POWERS, HAS JURISDICTION OVER ANY AND ALL MARIJUANA USE

In *Raich v. Ashcroft*, 352 F.3d 1222 (9th Cir. 2003), the Appellate Court reversed the District Court's decision denying the appellants' motion for a preliminary injunction halting enforcement of the federal Controlled Substances Act, 21 U.S.C. § 801 *et seq.* ("CSA"). The District

[1] Throughout this brief we use the term "crude marijuana" to describe the illicit Schedule I drug that people abuse. The drug is derived from the leaves and flowering tops of the Cannabis plant and is consumed in a variety of ways. The dried plant material is most often rolled in paper and smoked as a cigarette, called a "joint." It is often placed in smoking devices called "bongs," smoked in pipes, or smoked in "blunts," which are cigars from which the tobacco has been removed and replaced with marijuana plant material. Sometimes it is baked in cookies or brownies and eaten, or brewed in tea and drunk. Other methods for consuming the drug are constantly being developed by the drug culture, including versions that allegedly aerosolize crude marijuana to remove its "tars."

Court had found that the Commerce Clause [U.S. Const. art. I, sec 8, cl.3] supported the application of the CSA. The Appellate Court disagreed. Employing *United States v. McCoy*, 323 F.3d 1114 (9th Cir. 2003) as precedent, the Appellate Court found that the appellants' conduct may represent a "substantial portion" of the conduct covered by the relevant statute, and therefore can be examined as a "separate class of activity," which, if purely intrastate and having no effect on interstate commerce, can be outside the scope of the statute, and beyond the jurisdictional authority provided by the Commerce Clause. *Raich*, at 1228-1234. The court identified this separate class of activities as "the intrastate, non-commercial cultivation, possession and use of marijuana for personal medical purposes on the advice of a physician and in accordance with state law." *Id.*, at 1229. The state law to which the court refers is California's Compassionate Use Act, Cal. Health & Safety Code 11362.5. Using the foregoing analysis, the court found "a strong likelihood of success" to the appellants' claim for injunctive relief.

The obvious lynchpin in this "separate class" carved out by the court is the purported "medical use" of the marijuana. The Appellate Court itself conceded that, "Indeed, we have upheld the CSA in the face of past Commerce Clause challenges . . . [b]ut none of the cases in which the Ninth Circuit has upheld the CSA on Commerce Clause grounds involved the use, possession, or cultivation of marijuana for *medical purposes*." *Id.*, at 1227 (emphasis added). As Justice Beam pointed out in his dissent: "Except for why the marijuana at issue in this case is consumed, i.e., for medicinal rather that nutritional purposes, plaintiffs' conduct is entirely indistinguishable from that of Mr. Filburn's." *Id.*, at 1238. Justice Beam was referring to

the defendant in *Wickard v. Filburn*, 317 U.S. 111, 63 S.Ct. 82, 87 L.Ed. 122 (1942), in which, under the Commerce Clause, the Agriculture Adjustment Act reached Filburn's wheat growing activities, even that part of the crop grown for family food consumed in the home on the Filburn farm.

While the majority disagreed with Justice Beam's assertion that "[i]t is simply impossible to distinguish the relevant conduct surrounding the cultivation and use of the marijuana crop at issue in this case from the cultivation and use of the wheat crop that affected interstate commerce in *Wickard v. Filburn*" (*Raich*, at 1235), what is beyond dispute is that the majority's decision hangs solely on its (largely unexamined) premise that there exists a legitimate medical use for the ingestion of crude, or homegrown, marijuana. The Court's only bases for this premise appear to be the various state medical marijuana laws which permit the use of crude marijuana pursuant to a physician's recommendation. While these state laws may create an inference of legitimacy to the concept of "medical marijuana," they must be viewed in the context of, and weighed against, the body of unambiguous and preemptive federal law with which it plainly conflicts, and which has consistently held the position that there is no currently accepted medical use for crude marijuana.

There is a strong governmental interest in prohibiting the distribution of crude marijuana as medicine (See: Sections II and III, below). The federal government has expressly taken on the job of protecting our citizens from unsafe, ineffective substances sold as "medicines," and from drug abuse, drug addiction, and the abusive and criminal behaviors that marijuana and other illicit drugs often generate. Before any drug can be classified as "medicine," the drug must first be approved by the Food and

Drug Administration (the "FDA"). The federal Food, Drug, and Cosmetics Act, 21 U.S.C. §§ 351-360, gives the federal government, through the FDA, *sole responsibility* for determining that drugs are safe and effective, a requirement all medicines must meet before they may be distributed to the public. The FDA has not approved marijuana as safe or effective, so the drug may not legally be prescribed and sold as a medicine.

Not only has the FDA failed to approve marijuana, but has classified marijuana as a Schedule I controlled substance under the Controlled Substances Act. Schedule I drugs have "1) a high potential for abuse, 2) no currently accepted treatment in the United States, and 3) a lack of accepted safety for use of the drug ... under medical supervision." 21 U.S.C. § 812(b)(f).

In *Alliance for Cannabis Therapeutics v. DEA*, 15 F.3d 1131 (D.C. Cir. 1994), the United States District Court for the District of Columbia accepted the Drug Enforcement Administration's new five-part test for determining whether a drug is in "currently accepted medical use." *Id.* at 1135. The test requires that:

(1) The drug's chemistry must be known and reproducible;

(2) there must be adequate safety studies;

(3) there must be adequate and well-controlled studies proving efficacy;

(4) the drug must be accepted by qualified experts; and

(5) the scientific evidence must be widely available.

Applying these criteria to a petition to reschedule crude marijuana, the court found that the drug had no currently accepted medical use and, therefore, must remain a Schedule I substance. It should be noted that although the FDA has not approved crude marijuana as safe and effective, the FDA *has* approved medications to treat all of the diseases, symptoms, and ailments identified in California's Compassionate Use Act, and therefore, safe and effective legal alternatives to crude marijuana exist (See: Section II (b), below).

More recently, The FDA issued the following Statement, released in response to a congressional debate on the issue of medical marijuana use:

> The Food and Drug Administration (FDA) has concerns about any legislation that would prevent the Department of Justice or the Drug Enforcement Agency (DEA) from enforcing the Controlled Substances Act (CSA) with respect to marijuana either generally or in specified States. Marijuana is a Schedule I drug under the CSA. Schedule I substances are defined as having a high potential for abuse and no accepted medical use in the U.S. In 2001, the Department of Health and Human Services (HHS) completed an extensive analysis in response to a request to reschedule marijuana to a less restrictive schedule. After looking at all the relevant data on marijuana, HHS concluded that marijuana should continue to be controlled under Schedule I. DEA is the Federal agency with primary jurisdiction regarding enforcement actions relating to the sale or distribution of marijuana. FDA will continue to cooperate with DEA in these actions.

Several states have passed referenda making marijuana available for a variety of medical conditions, but these laws are in conflict with the CSA and often with the Federal Food, Drug, and Cosmetic (FD&C) Act. FDA's position continues to be that these ballot measures send the wrong message to the public – too many of whom do not recognize the dangers of marijuana – and that these measures are inconsistent with our efforts to ensure that approved medications have undergone rigorous scientific scrutiny and FDA's approval process.

FDA is the sole Federal agency that approves drug products as safe and effective for particular indications, and efforts that seek to bypass the FDA drug approval process would not serve the interests of public health. FDA has not approved marijuana for any indication. Only the disciplined, systematic, scientific conduct of clinical trials can establish whether there is any medicinal value to marijuana, smoked or otherwise.

> We reiterate that any legislation that would prevent the Department of Justice or the DEA from enforcing the CSA with respect to marijuana either generally or in specified States would not serve the interests of public health.[2]

In *United States v. Oakland Cannabis Buyers' Cooperative*, 523 U.S. 483 (2001), this Court held that "a medical necessity exception for marijuana is at odds with the terms of the Controlled Substances Act" because "its provisions leave no doubt that the defense is unavailable."

[2] FDA Statement, July 7, 2004. Released for House debate on issue of medical marijuana use; Patrick Ronan, Ass't Commissioner for Legislation, FDA.

Id., at 491. The Court added that "[t]he very point of our holding is that there is no medical necessity exception to the prohibitions at issue, even when the patient is seriously ill and lacks alternative avenues for relief." *Id.*, at 494 n.7. If "medical necessity" is insufficient to escape the scope of the CSA, then certainly mere "medical use" cannot suffice to comprise a separate distinct class of activity beyond the scope of the Controlled Substances Act.

Indeed, according to federal law, "medical marijuana" is a non sequitur. It cannot be re-animated, phoenix-like, at the state level, simply to create an otherwise unavailable refuge from the scope of the Commerce Clause.

II. ADVOCATES HAVE TRIED TO LEGALIZE MARIJUANA IN ONE FORM OR ANOTHER FOR THREE DECADES, AND THE "MEDICAL MARIJUANA" CONCEPT IS A TROJAN HORSE TACTIC TOWARDS THE GOAL OF LEGALIZATION

Drug-legalization advocates over the last three decades have employed a number of political and legal strategies to legalize marijuana. Between 1972 and 1978, the National Organization for the Reform of Marijuana Laws (NORML) successfully lobbied eleven state legislatures to "decriminalize" the drug, reducing penalties for possession in most cases to that of a traffic ticket. Also in 1972, NORML began the first of several unsuccessful attempts to petition the Drug Enforcement Administration (DEA) to reschedule marijuana from Schedule I to Schedule II on the grounds that crude marijuana had putative use in medicine. These attempts failed. See, *National Org. for the Reform of Marijuana Laws v. Ingersoll*, 497 F.2d 654 (D.C. Cir. 1974); *National Org. for the Reform of Marijuana Laws v. Drug Enforcement Admin.*, 559 F.2d 735 (D.C. Cir.

1977); *National Org. for the Reform of Marijuana Laws v. Drug Enforcement Admin. & Dept. of Health, Education & Welfare*, No. 79-1660 1980 U.S. App. LEXIS 13099 (D.C. Cir. Oct. 16, 1980); and *Alliance for Cannabis Therapeutics v. DEA*, 15 F.3d 1131 (D.C. Cir. 1994).

NORML and others led a second lobbying campaign aimed at states in the 1980s, this time to legalize crude marijuana as medicine. Some 35 states passed such laws. However, these laws were written by state legislative counsels, and so were appropriately drafted within the framework of federal law, establishing statewide research programs as directed by the applicable FDA guidelines. As a result, the advocates failed to get what they wanted – freely available marijuana.

In the early 1990s, NORML, the Drug Policy Foundation (DPF), and The Lindesmith Center (TLC) renewed the effort to legalize crude marijuana as medicine, this time using the state ballot initiative process, a process that allowed advocates to circumvent state legislative counsels and write their own laws. NORML, DPF, and TLC persuaded their most generous funders to create political organizations – Californians for Medical Rights and Arizonans for Drug Policy Reform – and to finance the first two medical marijuana initiatives in California and Arizona in 1996 and all subsequent initiatives that have passed since then. After the first two initiatives, Californians for Medical Rights became Americans for Medical Rights (AMR), which led successful medical marijuana initiative campaigns in 1998 in Alaska, Colorado, Nevada, Oregon, and Washington and in 1999 in Maine (See: Table 1). Similar initiatives were recently passed in Maryland and Vermont. Different sponsors succeeded in passing a

medical marijuana initiative in the District of Columbia 1998, with assistance from AMR.

California's Compassionate Use Act [Cal. Health & Safety Code 11362.5] legalizes crude marijuana for "the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, *or any other illness for which marijuana provides relief"* (emphasis added). After the proposition passed, its author told the press that *anyone* who uses marijuana is "self-medicating" and that therefore *all* marijuana use is for medical purposes. "The Return of Pot", Hanna Rosin, *The New Republic*, February 17, 1997.

A. The Fact That One Chemical In Marijuana Is An FDA-Approved Medicine Does Not Make Crude Marijuana An Approved Medicine.

Crude marijuana is derived from the leaves and flowering tops of the Cannabis plant. It contains some 400 chemicals, most of which have not been studied by scientists. Some 60 of these chemicals, called cannabinoids, are unique to the Cannabis plant. One cannabinoid, Delta_9_tetrahydrocannabinol (THC), was synthesized, tested, and approved by FDA in 1985 for treating nausea in cancer patients and wasting in AIDS patients. The drug's generic name is dronabinol and its trade name is Marinol^{R}. It is produced by Unimed Pharmaceuticals.

According to John A. Benson, Jr. M.D. of the Institute of Medicine, research on other cannabinoids is underway and some of these chemicals may one day prove to be useful medicines. However, he states:

> While we see a future in the development of chemically defined cannabinoid drugs, we see little future in smoked marijuana as a medicine.[3]

The fact that crude marijuana contains a chemical that has been synthesized, tested, and approved for medical use does not make marijuana itself a safe or effective medicine. Modern pharmaceutical science would require all the 400 or more chemicals in marijuana to pass the safety and efficacy tests in research, and this has not happened. Any consideration of this issue must take into account the substantial toxicity and morbidity associated with marijuana use. Because of the impurity of crude marijuana and its known toxic effects, it does not represent a useful medical alternative to currently available medications.

The current efforts to gain legal status of marijuana through ballot initiatives seriously threaten the Food and Drug Administration statutorily authorized process of proving safety and efficacy. The ballot initiative-led laws create an atmosphere of medicine by popular vote, rather than the rigorous scientific and medical process that all medicines must undergo. Before the development of modern pharmaceutical science, the field of medicine was fraught with potions and herbal remedies. Many of those were absolutely useless, or conversely were harmful to unsuspecting subjects. Thus evolved our current Food and Drug Administration and drug scheduling processes, which Congress has authorized in order to create a uniform and reliable system of drug approval and regulation.

[3] John A. Benson, Jr., Co-Principal Investigator, in releasing *Marijuana and Medicine: Assessing the Science Base*, Institute of Medicine, National Academy of Sciences, 1999.

This system is being intentionally undermined by the legalization proponents through use of medical marijuana initiatives.

B. Suitable And Superior Medicines Are Currently Available For Treatment Of All Symptoms Alleged To Be Treatable By Crude Marijuana.

Having extensively reviewed available therapies for chemotherapy-associated nausea, glaucoma, multiple sclerosis, and appetite stimulation,[4] Drs. Voth and Schwartz have determined that no compelling need exists to make crude marijuana available as a medicine for physicians to prescribe. They concluded that the most appropriate direction for THC research is to research specific cannabinoids or synthetic analogs rather than pursuing the smoking of marijuana. The conclusions of Drs. Voth and Schwartz were echoed a year later by the National Academy of Science's Institute of Medicine (hereinafter "IOM Report") in an assessment of scientific marijuana and cannabinoid research (see below).[5]

Available research on the utility of THC has demonstrated some effectiveness of the purified form of the drug in treating nausea associated with cancer chemotherapy.

[4] Voth EA, Schwartz RH. Medicinal Applications of Delta-9-Tetrahydrocannabinol and Marijuana. *Annals of Internal Medicine* 1997;126:791-798.

[5] *Marijuana and Medicine: Assessing the Science Base.* Janet E. Joy, Stanley J. Watson, Jr., and John A. Benson, Jr., Editors. Division of Neuroscience and Behavioral Health. Institute of Medicine, National Academy of Sciences. National Academy Press, Washington D.C., 1999.

Examples of such research include Sallan, et al.[6] who dealt only with pure THC in the treatment of chemotherapy-associated nausea, not smoked marijuana. Chang[7] tested THC and then followed treatment failures with marijuana, thus conclusions regarding effectiveness cannot be readily attributed to either THC or crude marijuana. Levitt[8] and coworkers actually determined that purified THC was more effective than smoked marijuana. Vinciguerra[9] found that smoked marijuana controlled nausea in patients who had failed other conventional forms of antiemetic therapy. Responders tended to have had prior marijuana experience. This study was uncontrolled and patients self-evaluated results. Smokers were required to inhale deeply, hold the smoke for ten seconds, and then smoke four cigarettes completely each day of chemotherapy. Twenty-five percent refused to smoke the marijuana. Over 20% of the subjects dropped out of the smoking group prior to the end of the study and 22% of the remaining subjects reported no benefit from smoking marijuana. Dosing was also variable because of the fact that the dose was rounded to the nearest one-fourth marijuana cigarette, and no THC levels were checked for consistency of dose response.

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[6] Sallan S S, et al. Antiemetics effects of delta-9-tetrahydrocannabinol in patients receiving cancer chemotherapy. *NEJM*. 1975;293:795-797.

[7] Chang et al. Delta-9-tetrahydrocannabinol as an antiemetic in cancer patients receiving high-dose methotrexate. *Annals of Internal Medicine*. 1979;91:819-924.

[8] Levitt et al. Randomized double blind comparison of delta-9-tetrahydrocannibinol and marijuana as chemotherapy antiemetics. *Proceedings of the Annual Meeting of the American Society of Clinical Oncology*. 1984:91

[9] Vinciguerra V, Moore T, Brennan E: Inhalation marijuana as an antiemetic for cancer chemotherapy. *N.Y. State J Med* 1988; 88:525-527.

Legalization advocates would have the public and policy makers incorrectly believe that crude marijuana is the only treatment alternative for masses of cancer sufferers who are going untreated for the nausea associated with chemotherapy, and for all those who suffer from glaucoma, multiple sclerosis, and other ailments. Numerous effective medications are, however, currently available for conditions such as nausea (See: Appendix, Table 2).

In fact, the IOM report found that neither smoked marijuana nor cannabinoids are as effective as current medicines that stop nausea and vomiting in cancer chemotherapy patients. However, the scientists speculated that cannabinoids might be effective in those few patients who respond poorly to current antiemetic (anti-nausea) drugs or more effective in combination with current antiemetics. It recommended that research should be pursued for patients who do not respond completely to current antiemetics and that a safe (non-smoking) delivery system for cannabinoids should be developed.

The negative side effect profile for marijuana, even oral dronabinol (Marinol^{R}), far exceeds most of the other effective agents available. *If* there exist treatment failures of available medications in these patients, the use of marijuana would, at minimum, demonstrate unpleasant side effects. In the studies performed to examine THC for chemotherapy-associated nausea, elderly patients could not tolerate the drug. Chronic, daily doses of the drug would be necessary to treat many of the proposed medical conditions. This would unnecessarily expose the patients to the toxic effects.

Mattes[10] compared oral and rectal suppository preparations of THC with smoked marijuana. All study subjects were experienced marijuana users thus accounting for a relatively high drug acceptance. Smoked marijuana was no more effective than suppository THC in stimulating appetite as measured by caloric energy intake. Rectal suppositories and oral THC were dosed at 2.5 mg twice daily. Marijuana subjects were required to inhale for 3 seconds, hold the smoke deeply in their lungs for 12 seconds, and then continue the process until the cigarette was smoked to a stub. The plasma THC levels peaked more quickly with the inhaled THC, but also fell more quickly, whereas the suppository THC maintained a more sustained level.

To examine the potential medical efficacy of marijuana as it relates to several disease states, a comprehensive review of the potential medicinal applications of marijuana was recently undertaken at the request of the Assistant Secretary of Health, Dr. Phillip Lee. Opinions were requested from investigators at the National Institute on Allergy and Infectious Diseases, who commented on the AIDS wasting syndrome; the National Cancer Institute who commented on the use of marijuana as an antiemetic in cancer chemotherapy; the National Eye Institute who commented on marijuana's use in glaucoma; and the National Institute for Neurological Disorders and Stroke who commented on marijuana's role as an antispasticity drug in multiple sclerosis. The summary opinion stated:

[10] Mattes RD, Engelman K, Shaw LM, Elsohly MA. Cannabinoids and appetite stimulation. *Pharmacologic Pharmacology, Biochemistry, and Behavior,* 1994;49:187-195.

> This evaluation indicates that sound scientific studies supporting these claims are lacking despite anecdotal claims that smoked marijuana is beneficial. Scientists at the National Institutes of Health indicate that after carefully examining the existing preclinical and human data, there is no evidence to suggest that smoked marijuana might be superior to currently available therapies for glaucoma, weight loss associated with AIDS, nausea and vomiting associated with cancer chemotherapy, muscle spasticity associated with multiple sclerosis, or intractable pain.[11]

The National Institutes of Health reconsidered this issue in 1997[12] and has called for further research into alternate delivery systems for pure THC as well as research into the comparative efficacy of marijuana with newer available medicines which have added heightened efficacy to medication regimes. The summary also called into attention concern over pulmonary, neuro-, and immuno-toxicity of cannabis.

In 1997 the White House Office of National Drug Control Policy commissioned the National Academy of Sciences Institute of Medicine (IOM) to undertake an evaluation of the utility of marijuana and other cannabinoids[13] for medicinal applications. The study concluded

[11] Lee PR, Letter to Congressman Dan Hamburg, United States Public Health Service, July 13, 1994

[12] Workshop on the Medical Utility of Marijuana. Report to the Director, National Institutes of Health. http://www.nih.gov/news/pr/aug97/nih-08.htm

[13] Marijuana and Medicine: Assessing the Science Base Janet E. Joy, Stanley J. Watson, Jr., and John A. Benson, Jr., Editors. Division of Neuroscience and Behavioral Health, Institute of Medicine. National Academy Press, Washington, D.C. 1999. Internet address www.nap.edu

that the challenge for future research will be to find cannabinoids which enhance therapeutic benefits while minimizing side effects such as intoxication and dysphoria. Delivery systems such as nasal sprays, metered dose inhalers, transdermal patches, and suppositories could be useful delivery systems for isolated or synthetic cannabinoids (See: Appendix, Table 3). The future for medicinal applications of cannabinoids and whether cannabinoids are equal or superior to existing medicines remains to be determined, but the IOM evaluation is particularly clear on the smoking of marijuana:

> If there is any future for marijuana as a medicine, it lies in its isolated components, the cannabinoids and their synthetic derivatives. Isolated cannabinoids will provide more reliable effects than crude plant mixtures. Therefore, the purpose of clinical trials of smoked marijuana would not be to develop marijuana as a licensed drug, but such trials could be a first step towards the development of a rapid-onset, non-smoked cannabinoid delivery system.[14]

The following excerpts from the IOM report are instructive:

> The goal for drugs that treat nausea and vomiting produced by cancer chemotherapy is complete control (stop vomiting completely) or major control (two or fewer episodes of vomiting). . . .[15] A controlled double-blind study compared THC with a standard antiemetic drug, metoclopramide, in cancer patients who received cisplatin,

[14] IOM Report, p. 20.

[15] Ibid., p. 4.11.

> the chemotherapeutic drug that causes vomiting in more than 99 percent of patients. . . .[16]

Results	Complete Control	Major Control
Metoclopramide	47 percent	73 percent
THC	13 percent	27 percent

> (Other study) results suggest that THC reduces chemotherapy-induced emesis. These studies also indicate that the degree of efficacy is not high. . . .[17] As with the THC trials, nabilone and levonantradol (two synthetic analogues of THC) reduced emesis, but not as well as other available agents. . . .[18] A double-blind, cross-over, placebo controlled study compared THC pills to smoked marijuana in 20 cancer patients receiving a variety of chemotherapeutic drugs. Only 25 percent of patients achieved complete control of vomiting. . . .[19]

Preferred THC Pills	35 percent
Preferred Marijuana	20 percent
No Preference	45 percent

> Although many marijuana users have claimed that smoked marijuana is a more effective antiemetic than oral THC, no controlled studies have yet been published that analyze this in sufficient detail to estimate the extent to which that is the case. . . .[20] *Major progress, generally not well-known to the public, in controlling chemotherapy-induced acute nausea and vomiting has*

[16] Ibid., p. 4.11-4.12.

[17] Ibid., p. 4.12.

[18] Ibid., p. 4.13.

[19] Ibid., p. 4.13.

[20] Ibid., p. 4.14.

been made since the 1970s (emphasis added). Patients receiving the most difficult to control emetic agents now have no more than a 20-30 percent likelihood of experiencing acute emesis, whereas in the 1970s the likelihood was nearly 100 percent despite (then standard) antiemetics. . . . [21] Cannabinoids are not as effective as several other classes of agents . . . . As with cannabinoids, efficacy was apparent with smoked marijuana, but the degree of efficacy was no better than that seen with available antiemetic agents now considered to be marginally satisfactory. It is theoretically possible . . . that added to more effective regimens, THC might enhance control of emesis. . . . The critical issue is not whether marijuana or cannabinoid drugs might be superior to the new drugs, but rather whether there is a group of patients who might obtain added or better relief from marijuana or cannabinoid drugs. . . .[22] Most chemotherapy patients are unlikely to want to use marijuana or THC as an antiemetic. In 1998, there were more effective antiemetic agents available than were available earlier. By comparison, cannabinoids are only modest antiemetics . . . .However . . . cannabinoids might be effective in people who respond poorly to currently used antiemetic drugs, or cannabinoids might be more effective in combination with the new drugs than either are alone. . . .Therefore research should be pursued for patients whose nausea and vomiting is not completely controlled by standard antiemetics. . . . Antiemetic pills are given to cancer patients before chemotherapy begins and then

[21] Ibid., p. 4.15.

[22] Ibid., p. 4.16.

afterwards. In those patients who nonetheless experience nausea and vomiting after chemotherapy, "an inhalation (but preferably not smoking) cannabinoid drug delivery system would be advantageous for treating chemotherapy-induced nausea."[23]

C. Crude Marijuana Use Entails Numerous Significant And Proven Negative Effects.

Marijuana adversely impacts concentration, motor coordination, and memory,[24] factors that must be considered in any discussion of providing this drug to patients suffering chronic diseases. The ability to perform complex tasks, such as flying,[25] is impaired even 24 hours after the acute intoxication phase. The association of marijuana use with trauma and intoxicated motor vehicle operation is also well established.[26] This is of central importance in an ambulatory environment where patients may smoke marijuana and then drive automobiles. Recent evaluations[27] of the effect of marijuana on driving determined

[23] Ibid., p. 4.17.

[24] Murray J B. Marijuana's effects on human cognitive functions, psychomotor functions, and personality. *Journal of General Psychology.* 1986;113:23-55.

[25] Yesavage J A, Leirer V O, Denari M, and Hollister L E. Carryover effects of marijuana intoxication on aircraft pilot performance; a preliminary report. *Am. J. Psychiatry.* 1985;142:1325-1329.

[26] Gerostamoulos J., and Drummer O H. Incidence of psychoactive cannabinoids in drivers killed in motor vehicle accidents. *Journal of Forensic Sciences.* 1993;38:649-656.

[27] National Highway Traffic Safety Administration. Marijuana and Alcohol Severely Impede Driving Performance. *Annals of Emergency Medicine*2000:35;398-399. NHTSA study– National Highway Traffic Safety Administration. Marijuana Alcohol and Actual Driving Performance. DOT HS 808.939

that the combination of blood alcohol concentrations (BAC) of 0.07 and marijuana 100ug/kg gave effects similar to a BAC of 0.09. Blood alcohol concentrations of 0.07 and marijuana levels of 200ug/kg demonstrated effects similar to a BAC of 0.14 when measuring reaction time, on-road performance, and vehicle following. The study concluded, "Under marijuana's influence, drivers have reduced capacity to avoid collisions if confronted with the sudden need for evasive action." A second related study found that a BAC of .05 combined with moderate marijuana produced a significant drop in the visual search frequency.

Positron scanning[28] of subjects' mean use of marijuana 17 times per week for the last 2 years found lower blood flow in a large region of the posterior cerebellum. Not only does this have implications on motor coordination and function, but also cognition, timing, processing sensory information, and attention.

Despite arguments of the legalization advocates to the contrary, marijuana is a dependence-producing drug. Strangely, in the course of the rescheduling hearings, petitioners admitted that "marijuana has a high potential for abuse and that abuse of the marijuana plant may lead to severe psychological or physical dependence." These are points which they now deny. However, this dependence and associated "addictive" behaviors have been well

[28] Block RI, O'Leary DS, Hichwa RD, Augustinack JC, Boles-Ponto LL, Ghoneim M M, Arndt S, Ehrhardt JC, Hurtig RH, Watkins GL, Hall JA, Nathan PE, Andreasen NC. Cerebellar hypoactivity in frequent marijuana users. *NeuroReport* 2000;4:749-753

described in the marijuana literature.[29] [30] [31] Marijuana dependence consists of both a physical dependence (tolerance and subsequent withdrawal) and a psychological dependence. Withdrawal from marijuana has been demonstrated in both animals[32] and humans.[33]

While the dependence producing properties of marijuana are probably a minimal issue for chemotherapy-associated nausea when medication is required sporadically, it is a major issue for the chronic daily use necessary for glaucoma, AIDS wasting syndrome, and other alleged chronic applications.

The respiratory difficulties associated with marijuana use preclude the inhaled route of administration as a medicine. Smoking marijuana is associated with higher concentrations of tar, carbon monoxide, and carcinogens than are found in cigarette smoking.[34] Marijuana adversely impairs some aspects of lung function and causes abnormalities in the respiratory cell lines from large

[29] Compton D R, Dewey W L, and Martin B R. Cannabis dependence and tolerance production. *Advances in Alcohol and Substance Abuse.* 1990;9:129-147.

[30] Miller N S, and Gold M S. The diagnosis of marijuana (cannabis) dependence. *Journal of Substance Abuse Treatment.* 1989;6:183-192.

[31] Schwartz R H. Marijuana: an overview. *Pediatric clinics of North America.* 1987;34:305-317

[32] Martin BR. The THC receptor and its antagonists. In: Nahas GG, Burks TF, eds. Drug Abuse in the Decade of the Brain. Amsterdam: IOS press;1997:139-144.

[33] Duffy A, Milin R, Case Study: Withdrawal Syndrome in Adolescent Chronic Cannabis Users. *J. Am. Acad Child Adolesc Psychiatry.* 1996;35:1618-21.

[34] Wu T C, et al. Pulmonary hazards of smoking marijuana as compared with tobacco. *NEJM.* 1988;318:347-351.

airways to the alveoli.[35] [36] Marijuana smoke causes inflammatory changes in the airways of young people that are similar to the effects of tobacco.[37] In addition to these cellular abnormalities and consequences, contaminants of marijuana smoke are known to include various pathogenic bacteria and fungi.[38] Those at particular risk for the development of disease and infection when these substances are inhaled are those users with impaired immunity.

One of the earliest findings in marijuana research was the effect on various immune functions, which is now evidenced by an inability to fight herpes infections and the discovery of a blunted response to therapy for genital warts during cannabis consumption.[39] Abnormal immune function is, of course, the cornerstone of problems associated with AIDS. The use of chronic THC in smoked form for AIDS wasting not only exposes the patient to unnecessary pathogens, but also risks further immunosuppression. Evaluation of the effect of THC on NK-*k*B has suggested a possible effect on the HIV genome. A hallmark

[35] Tashkin D P, Shapiro B J, Lee Y E, and Harper C E. Subacute effects of heavy marijuana smoking on pulmonary function in healthy men. *NEJM*. 1976;294:125-129.

[36] Barbers R G, et al. Differential examination of bronchoalveolar lavage cells in tobacco cigarette and marijuana smokers. *Am Rev Respir Dis*1987;135:1271

[37] Roth MD, Arora A, Barsky SH, Kleerup EC, Simmons M, Tashkin DP. Airway inflammation in young marijuana and tobacco smokers. *Am J. Respir Crit Care Med* 1998;157:928-937

[38] Fleisher M, Winawer S J, and Zauber A G. Aspergillosis and marijuana. *Annals of Internal Medicine.* 1991;115:578-579.

[39] Gross G, Roussaki A, Ikenberg, Drees N. Genital warts do not respond to systemic recombinant interferon alfa-2 treatment during cannabis consumption. *Dermatologica* 1991; 183:203-207

of the treatment for AIDS is *avoidance* of drug use, not extension or perpetuation of it. It should be clear that marijuana exposes the user to substantial health risks. In chronic use, or use in populations at high risk for infection and immune suppression, the risks are unacceptable.

Amici assert that in the interest of protecting seriously and terminally ill patients from unsafe and ineffective drugs, the safety and efficacy process of the FDA cannot be bypassed. The FDA has thoroughly examined the possible use and/or re-classification of crude marijuana, and it has correctly determined that crude marijuana is an impure and toxic substance that has no place in the medical armamentarium. Furthermore, by means of its appropriate regulatory processes, the FDA remains available to petitioning for reclassification, should sufficient evidence for such change of classification arise. To date, it has not.

Recently, the medical excuse marijuana movement has been compared to a Pandora's Box which threatens to jeopardize public safety and consumer protection if opened.[40] Coupled with the medical risk to patients, serious regulatory questions arise that have not been adequately dealt with by ballot initiatives. Those who propose medical uses, or who conduct research on the use of marijuana, have an ethical responsibility not to expose their subjects to unnecessary risks. Under current guidelines, crude marijuana is not a medicine, and allowing it as such would be a step backward to the times of potions and herbal remedies.

[40] Voth, EA, *A Peek Into Pandora's Box: The Medical Excuse Marijuana Controversy.* J. Addict. Diseases 2003; 22:27-46

III. THE PUBLIC'S DIMINISHED PERCEPTION OF HARM REGARDING THE USE OF MARIJUANA INCREASES ITS ILLICIT USE

Amici note the profound correlation in benchmark surveys of drug use, which show that the more people who believe a drug is harmful, the fewer people use that drug. Equally profound are the surveys' findings that the reverse is also true: the fewer people who believe a drug is harmful, the more people use that drug. These surveys show that perception of harm with respect to marijuana has been dropping off annually since the renewal of the drive to legalize marijuana as medicine, which began in the early 1990s when legalization advocates first gained a significant increase in funding and began planning the state ballot initiative drive to legalize crude marijuana as medicine. The surveys are the Monitoring the Future Survey, which has tracked drug use among American high school students annually since 1975[41] and the National Household Survey on Drug Abuse, which has tracked drug use among Americans ages 12 and older annually or less frequently since 1972.[42]

The 1999 National Household Survey on Drug Abuse, released in October 2000, was conducted for SAMHSA (the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services) by North

[41] *Monitoring the Future,* National Institutes of Health, National Institute on Drug Abuse, available on the Internet at <www.monitoringthefuture.org>.

[42] *Summary of Findings from the 1999 National Household Survey on Drug Abuse*, Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Rockville MD, 2000, pp 64-65, 74-75.

Carolina's Research Triangle Institute.[43] For the first time in the history of this survey, the population sample was vastly increased (from an average of 15,000 to 75,000) in order to provide data about individual states, as well as about the nation as a whole. The state data for the 1999 survey reveals that those states which have passed medical marijuana laws have among the highest levels of past-month marijuana use, of past-month other drug use, of drug addiction, and of drug and alcohol addiction (See: Appendix, Table 4):

> **Drug Addiction** – Alaska and Nevada had the highest rates of drug addiction in the nation, California and Oregon have the 4th highest rates, the District of Columbia has the 5th highest rate, Washington has the 6th highest rate, Arizona and Colorado have the 7th highest rates, and Maine has the 12th highest rate.[44]
>
> **Drug Use** – Alaska has the highest rate of past-month drug use in the nation, Nevada has the 3rd highest rate, Colorado has the 4th highest rate, Washington has the 8th highest rate, California has the 9th highest rate, Oregon has the 11th highest rate, the District of Columbia has the 12th highest rate, and Arizona and Maine have the 15th highest rate.[45]

In 2003 SAMHSA released a follow-up survey, the 2002 National Survey on Drug Use and Health. The results confirm the 1999 findings, and demonstrate a consistent clustering of drug-use issues in states which

[43] Ibid.

[44] Ibid.

[45] Ibid.

have adopted medical marijuana ballot-measures (See: Appendix, Table 5).

> **Drug Addiction and Abuse** – *All* of the medical marijuana ballot-initiative states are now clustered at or near the top of the list in terms of drug addiction and abuse. California and Nevada have the highest rates in the nation. These medical marijuana ballot-initiative states occupy three of the top four slots, and six of the top ten slots. The nine medical marijuana ballot-initiative states now occupy nine of the top seventeen slots in ranking of drug addiction and abuse.[46]
>
> **Drug Use** – The medical marijuana ballot-initiative states now occupy five of the top seven slots in terms of the rate of past-month drug use in the nation. Only Massachusetts and Vermont have higher rates than these five states (Alaska, Colorado, Oregon, Maine, and California), and Vermont has itself passed a medical marijuana ballot-initiative in the past year. All of the medical marijuana ballot-initiative states are at or significantly above the national average.[47]

Amici are concerned that the current medical marijuana initiatives compromise the protection of seriously and terminally ill patients by exposing them to an unapproved drug. So-called medical marijuana laws mask the proven health risks inherent in crude marijuana use, both

[46] Substance Abuse and Mental Health Services Administration. (2003) *Overview of Findings from the 2002 National Survey on Drug Use and Health* (Office of Applied Studies, NHSDA Series H-21, DHHS Publication No. SMA 03-3774). Rockville, MD

[47] Ibid.

in practice and in perception, and they compromise the safety and proper treatment of these patients. In contrast, we have *no* objection to any medicines that may evolve from the cannabinoids, including Marinol, provided that they are approved as safe and effective by the Food and Drug Administration under current federal law.

Amici are also concerned that legalization advocates' efforts to confuse the public about the difference between crude marijuana and the cannabinoids that scientists are studying for possible use in medicine, have contributed to the past decade's drop in the perception of marijuana's harm. This has resulted in an increase in marijuana use, other drug use, and drug addiction. The continued acceptance of the crude-marijuana-as-medicine concept will only worsen these problems.

CONCLUSION

Amici believe that it is critically important that the Supreme Court uphold the supremacy of the federal FDA regulatory process, and its carefully researched determination that there is no currently accepted medical use for crude, or home-grown, marijuana, and that therefore there can be no "medical use" exception to the Controlled Substances Act. Logically, then, the Appellate Court cannot create a distinct class of activities out of the "medical use" subgroup, and therefore the alleged medical use of marijuana is an activity which must come under the jurisdiction of the federal Controlled Substance Act, as authorized

by the Commerce Clause of the U.S. Constitution. Accordingly, the decision of the Appellate Court should be reversed.

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APPENDIX

TABLE 1

States That Have Passed Medical Marijuana Initiatives[49]

California
Proposition 21
The Compassionate Use Act of 1996

Arizona
Proposition 200
The Drug Medicalization, Prevention, and Control Act of 1996

Proposition 300
A 1998 initiative to reinstate certain provisions of proposition 200

Alaska
A 1998 Act Relating to the Medical Use of Marijuana for Persons Suffering from Debilitating Medical Conditions

Colorado
Medical Use of Marijuana for Persons Suffering from Debilitating Medical Conditions Passed in 1998, but invalidated by the Colorado Supreme Court for insufficient signatures.

Nevada
Medical Marijuana Initiative of 1998

Oregon
Oregon Medical Marijuana Act of 1998

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[49] National Families in Action: A Guide to Drug-Related State Ballot Initiatives, Initiative Index, www.nationalfamilies.org/guide/initiative_index.html.

Washington
Initiative 692
Medical Use of Marijuana Act of 1998

District of Columbia
Initiative 59
Legalization of Marijuana for Medical Treatment Initiative of 1998 Different sponsors but assisted by Americans for Medical Rights

Maine
A 1999 Act to Permit the Medical Use of Marijuana

Colorado
Medical Use of Marijuana for Persons Suffering from Debilitating Medical Conditions Passed in 2000.

Nevada
Medical Marijuana Initiative of 2000
Second vote required to amend state constitution

TABLE 2

EXAMPLES OF NON-CANNABINOID MEDICATIONS AVAILABLE FOR NAUSEA ASSOCIATED WITH CANCER CHEMOTHERAPY

Serotonin Antagonists
Ondansetron (Zofran)
Granisetron (Kytril)
Tropisetron (Navoban)
Dolasetron

Phenothiazines:
Prochlorperazine (Compazine)
Chlorpromazine (Thorazine)
Thiethylperazine (Torecan)
Perphenazine (Trilafon)
Promethazine (Phenergan)

Corticosteroids
Dexamethasone (Decadron)
Methylprednisolone (Medrol)

Anticholinergics
Scopolamine (Trans Derm Scop)

Butyrophenones
Droperidol (Inapsine)
Haloperidol (Haldol)
Domperidone (Motilium)

Benzodiazepines
Lorazepam (Ativan)
Alprazolam (Xanax)

Substituted Benzamides
Metoclopramide (Reglan)
Trimethobenzamide (Tigan)
Alizapride (Plitican)
Cisapride (Propulsid)

Antihistamines
Diphenhydramine (Benedryl)

TABLE 3

Institute of Medicine Recommendations[50]

Recommendation 1: Research should continue into the physiological effects of synthetic and plant-derived cannabinoids and the natural function of cannabinoids found in the body. Because different cannabinoids appear to have different effects, cannabinoid research should include, but not be restricted to, effects attributable to THC alone.

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[50] IOM Report, p. ES. 11.

Recommendation 2: Clinical trials of cannabinoid drugs for symptom management should be conducted with the goal of developing rapid-onset, reliable, and safe delivery systems.

Recommendation 3: Psychological effects of cannabinoids such as anxiety reduction and sedation, which can influence perceived medical benefits, should be evaluated in clinical trials.

Recommendation 4: Studies to define the individual health risks of smoking marijuana should be conducted, particularly among populations in which marijuana use is prevalent.

Recommendation 5: Clinical trials of marijuana use for medical purposes should be conducted under the following limited circumstances: trials should involve only short-term marijuana use (less than six months); be conducted in patients with conditions for which there is reasonable expectation of efficacy; be approved by institutional review boards; and collect data about efficacy.

Recommendation 6: Short-term use of smoked marijuana (less than six months) for patients with debilitating symptoms (such as intractable pain or vomiting) must meet the following conditions:

- failure of all approved medications to provide relief has been documented,
- the symptoms can reasonably be expected to be relieved by rapid-onset cannabinoid drugs,
- such treatment is administered under medical supervision in a manner that allows for assessment of treatment effectiveness, and

- involves an oversight strategy comparable to an institutional review board process that could provide guidance within 24 hours of a submission by a physician to provide marijuana to a patient for a specified use.

Note: Recommendations 5 and 6 are consistent with current FDA research guidelines. The IOM report cautions that "the purpose of clinical trials of smoked marijuana, using research-grade marihuana rather than street marijuana," "*would not be to develop marihuana as a licensed drug*, but such trials could be a first step towards the development of a rapid-onset, nonsmoked cannabinoid delivery system." (emphasis added) See our footnote 14.

1999 National Household Survey on Drug Abuse[1]

(Highlighted states have passed medical marijuana initiatives since 1996)

Percent Reporting Past-Year Drug Dependence

State	Ranking	Rate
Alaska	**1**	**2.8**
Nevada	**1**	**2.8**
New Mexico	2	2.7
Delaware	3	2.4
California	**4**	**2.3**
Oregon	**4**	**2.3**
District of Columbia	**5**	**2.2**
Washington	**6**	**2.1**
Rhode Island	6	2.1
Massachusetts	6	2.1
Arizona	**7**	**2.0**
Colorado	**7**	**2.0**
Utah	7	2.0
Vermont	7	2.0
Connecticut	8	1.9
Montana	8	1.9
Michigan	9	1.8
New Hampshire	9	1.8
New York	9	1.8
National Average		1.7
Kansas	10	1.7
Louisiana	10	1.7
Minnesota	10	1.7
Mississippi	10	1.7
New Jersey	10	1.7
Wyoming	10	1.7
Illinois	11	1.6
Indiana	11	1.6
Maryland	11	1.6
Missouri	11	1.6
Ohio	11	1.6
Wisconsin	11	1.6
Maine	**12**	**1.5**
Idaho	12	1.5
Georgia	12	1.5
North Carolina	12	1.5
North Dakota	12	1.5
Oklahoma	12	1.5
Pennsylvania	12	1.5
Tennessee	12	1.5
Alabama	13	1.4
Arkansas	13	1.4
Hawaii	13	1.4
Nebraska	13	1.4
South Carolina	13	1.4
South Dakota	13	1.4
Texas	13	1.4
Florida	14	1.3
Kentucky	14	1.3
Virginia	15	1.3
Iowa	16	1.2
West Virginia	16	1.2

Percent Reporting Past-Month Drug Use

State	Ranking	Rate
Alaska	**1**	**10.7**
Massachusetts	2	10.1
Nevada	**3**	**9.6**
Colorado	**4**	**9.3**
New Mexico	5	8.9
Rhode Island	6	8.7
Delaware	7	8.5
Washington	**8**	**8.4**
California	**9**	**8.3**
Michigan	10	8.0
Oregon	**11**	**7.7**
Montana	11	7.7
New Jersey	11	7.7
Connecticut	11	7.7
District of Columbia	**12**	**7.6**
Indiana	13	7.5
Wyoming	14	7.3
Arizona	**15**	**7.1**
Maine	**15**	**7.1**
Hawaii	15	7.1
New/ Hampshire	16	7.0
New York	16	7.0
Pennsylvania	16	7.0
Wisconsin	16	7.0
National Average		6.9
Illinois	17	6.9
Florida	18	6.8
Vermont	18	6.8
Minnesota	19	6.7
Missouri	20	6.6
Ohio	21	6.5
Idaho	22	6.4
North Carolina	23	6.3
Utah	24	6.2
Kentucky	25	6.0
South Dakota	25	6.0
Kansas	26	5.9
Georgia	27	5.8
Mississippi	27	5.8
Louisiana	28	5.7
Nebraska	29	5.6
Iowa	30	5.5
Tennessee	30	5.5
North Dakota	31	5.4
South Carolina	31	5.4
Texas	31	5.4
Maryland	32	5.3
Alabama	33	5.1
Oklahoma	33	5.1
West Virginia	33	5.1
Arkansas	34	5.0
Virginia	35	4.7

2002 National Household Survey on Drug Abuse[2]

(Highlighted states have passed medical marijuana initiatives since 1996)

Percent Reporting Past-Year Drug Dependence and Abuse		
State	Ranking	Rate
California	**1**	**2.9**
Nevada	**1**	**2.9**
Massachusetts	2	2.8
Washington	**2**	**2.8**
Vermont	3	2.7
Louisiana	3	2.7
Connecticut	3	2.7
Arizona	**4**	**2.6**
Colorado	**4**	**2.6**
Oregon	**4**	**2.6**
New Mexico	4	2.6
Delaware	4	2.6
District of Columbia	**5**	**2.5**
Alaska	**5**	**2.5**
New York	5	2.5
Montana	5	2.5
Maine	**6**	**2.4**
Maryland	6	2.4
Arkansas	6	2.4
New Hampshire	6	2.4
Tennessee	6	2.4
Illinois	6	2.4
Minnesota	7	2.3
Kentucky	7	2.3
Mississippi	7	2.3
Utah	7	2.3
National Average		2.25
Oklahoma	8	2.2
Michigan	8	2.2
Idaho	9	2.1
Rhode Island	10	2.0
Hawaii	10	2.0
Indiana	10	2.0
Texas	10	2.0
North Carolina	10	2.0
Georgia	10	2.0
Kansas	10	2.0
Wisconsin	10	2.0
Wyoming	10	2.0
West Virginia	10	2.0
Florida	11	1.9
Ohio	11	1.9
Alabama	12	1.8
Nebraska	12	1.8
New Jersey	12	1.8
Pennsylvania	12	1.8
South Carolina	13	1.7
South Dakota	13	1.7
Missouri	13	1.7
Virginia	14	1.6
North Dakota	14	1.6
Iowa	15	1.4

Percent Reporting Past-Month Drug Use		
State	Ranking	Rate
Massachusetts	1	10.7
Vermont	2	10.5
Alaska	**3**	**9.2**
Colorado	**3**	**9.3**
Oregon	**4**	**8.7**
Maine	**5**	**8.4**
California	**6**	**8.2**
Rhode Island	6	8.2
District of Columbia	**7**	**8.1**
New Hampshire	8	8.0
North Carolina	9	7.9
Washington	**10**	**7.7**
Delaware	11	7.6
Connecticut	12	7.5
Hawaii	12	7.5
Michigan	12	7.5
New Mexico	12	7.5
Nevada	**13**	**7.3**
Illinois	14	7.2
New York	15	6.8
National Average		6.7
Arizona	**16**	**6.7**
Arkansas	16	6.7
Kentucky	16	6.7
Louisiana	16	6.7
Minnesota	17	6.6
Wisconsin	18	6.3
Montana	18	6.3
Maryland	19	6.2
Tennessee	19	6.2
Georgia	20	6.1
Kansas	20	6.1
Florida	21	6.0
Pennsylvania	22	5.9
Ohio	22	5.9
New Jersey	23	5.8
Alabama	23	5.8
Wyoming	24	5.7
South Carolina	24	5.7
Missouri	24	5.7
Mississippi	24	5.7
Virginia	25	5.5
Oklahoma	26	5.4
Idaho	26	5.4
Texas	27	5.3
Indiana	28	5.2
West Virginaia	29	5.0
Utah	29	5.0
Nebraska	30	4.6
Iowa	31	4.5
South Dakota	31	4.5
North Dakota	32	4.1

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